

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:  HARRIS METHODIST HEB 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-8200-01
Respondent Name and Box #:  DALLAS NATIONAL INSURANCE CO Rep Box # 20	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Requestor's Position Summary: "140% over APC allowable for fair and reasonable."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1085.53
3. Hospital Bill
4. EOBs
5. Medical Records

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Respondent's Position Summary: "The Requesting Party appears to believe that they are entitled to reimbursement based on the Medicare rate with a percentage increase. However, the Requestor offers no basis for this assertion. And the Requestor is wrong. As the EOBs correctly reflect, the charges were reduced for a number of reasons. First, many of the charges were reduced because they reflected bundled charges that were a part of other services already allowed for. Secondly, the charges were reduced to appropriately reflect the Workers Compensation State Fee Schedule. Finally, come of the charges were reduced to reflect the normal geographical charge."

Principal Documentation:

1. Response Package

**PART IV: SUMMARY OF FINDINGS**

Date of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/16/2006	380, 600, 97, W1, W10, L01, L02, L03	Outpatient Surgery	\$1085.53	\$0.00
<b>Total /Due:</b>				\$0.00

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- 380-Recommendation is based on attached invoice.
- 600-Reimbursement based on usual, customary and reasonable for this geographic region.
- 97-Payment is included in the allowance for another service/procedure. Charge is considered inclusive in the fair and reasonable recommended allowance.
- W1-Workers Compensation State Fee Schedule Adjustment.

- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Recommended allowance is considered fair and reasonable. Fair & reasonable based on comparison of services performed & reimbursed in your geographic area.
  - L01-Recommended allowance is considered fair and reasonable.
  - L02-Fair & reasonable based on comparison of services performed & reimbursed in your geographic area.
  - L03-Charge is considered inclusive in the fair and reasonable recommended allowance.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
  3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
  4. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of all medical bill(s)”... “as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter”... This request for medical fee dispute resolution was received by the Division on July 21, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and as submitted for reconsideration. The dispute packet is missing a reconsideration bill. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
  5. Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of each explanation of benefits (EOB) relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier’s response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
  6. Division rule at 28 TAC §133.307(c)(2)(C), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division”... Review of the documentation submitted by the requestor finds that the documentation does not support that the services in dispute were rendered on the dates of service listed on the requestor’s *Table*. The requestor noted on the *Table* that the disputed date is 10-16-06 for total charges of \$6196.84; however, the submitted medical bills and EOBs are for date of service 10/18/06 for total charges of \$6196.84. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(C).
  7. Division rule at 28 TAC §133.307(c)(2)(F)(ii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “the requestor’s reasoning for why the disputed fees should be paid or refunded”... Review of the requestor’s position statement finds that the requestor has not discussed why the disputed fees should be paid. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(ii).
  8. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... Review of the requestor’s position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
  9. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the submitted documentation supports the requestor position for each disputed fee issue.”...Review of the requestor’s documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).

10. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to requests for medical fee dispute resolution filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”... The requestor’s position statement asserts that “140% over APC allowable for fair and reasonable.” The requestor did not list which APC was used in their position statement to determine the rate. Furthermore, the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.
11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), §133.307(c)(2)(C), §133.307(c)(2)(F)(ii), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv), and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.307, §134.1, §133.250  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION AND/OR ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

11/24/2009  
\_\_\_\_\_  
Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**